s IOWA'S APPLICATION FOR STATE CHILD HEALTH PLAN UNDER TITLE XXI OF THE SOCIAL SECURITY ACT STATE CHILDREN'S HEALTH INSURANCE PROGRAM

(Required under 4901 of the Balanced Budget Act of 1997 (New section 2101(b)))

State/Territory: State of Iowa	/** #
As a condition for receipt of Federal funds under Title X	XI of the Social Security Act,
Terry E. Branstad, Governor	May 37, 1998 Date
submits the following State Child Health Plan for the Stand hereby agrees to administer the program in accordance State Child Health Plan, the requirements of Title XXI applicable Federal regulations and other official issuance	nce with the provisions of the and XIX of the Act and all
Proposed Effective Date: July 1, 1998	
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ATTACHMENT "B"	State Plan Amendment - Attachment 2.2-A, pages 23b and 23c
ATTACHMENT "C"	State Plan Amendment • Attachment 2.6-A, page 6a
ATTACHMENT "D"	State Plan Amendment - Attachment 2.6-A, page 11a
ATTACHMENT "E"	state Plan Amendment • Supplement 1 to Attachment 2.6-A, page 2
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ATTACHMENT "H"	State Plan Amendment - Supplement 8a to Attachment 2.6-A, page 1
ATTACHMENT "T"	"Iowa Kids" - Report of the State Children's Health Insurance Program (SCHIP) Task Force
ATTACHMENT "J"	Map of Public Forum Sites
ATTACHMENT "K"	Healthy Kids in Iowa Brochure (over 70,000 mailed out)
ATTACHMENT "L"	Healthy Kids in Iowa Pamphlet (provided at public forums)
ATTACHMENT"M"	Refugee Resettlement Statistics
ATTACHMENT "N"	Child Health Specialty Clinics Brochure
ATTACHMENT"O"	"Reaching Uninsured Children" - Outreach Program for Children Eligible for Medicaid and Healthy and Well Kids in Iowa (HAWK-I) Request for Proposal

Section 1. General Description and Purpose of the State Child Health Plans (Section 2101)

The state will use funds provided under Title XXI primarily for (Check appropriate box):

- 1.1. Obtaining coverage that meets the requirements for a State Child Health Insurance Plan (Section 2103); OR
- 1.2. Providing expanded benefits under the State's Medicaid plan (Title XIX); OR
- 1.3. **A** combination of both of the above.

Effective July 1,1998, the State will expand its Medicaid program to cover children up to age 19, in families with incomes at or below 133% of the Federal Poverty Level (FPL). Infants, up to 1 year of age, are currently covered if family income does not exceed 185% of FPL and children under age 6 are currently covered if family income does not exceed 133% of FPL. This expansion provides coverage for children ages 6 through 14 between 100% and 133% of FPL and for children ages 15 through 18 between 37% and 133% of FPL.

Attachments A through H to this State CHIP Plan consists of eight Medicaid State Plan Amendments that will co-exist to effect Iowa's Medicaid eligibility expansion. These amendments expand Medicaid eligibility, as authorized by 1902(a)(10)(A), from its level as of July 1, 1998, to children up to the age of 19 in families with incomes at or below 133% of FPL for optional targeted low-income children. The state is also submitting a Medicaid State Plan amendment so that children who do not meet the definition of optional targeted low-income children can still be found Medicaid eligible. The Medicaid State Plan amendment, as authorized by 1903 (accelerated SOBRA) and 1902(r)(2), will allow the State to provide Medicaid coverage to children who meet the income requirements for the eligibility expansion but who have creditable coverage.

The State **has** implemented systems changes that allow for identification of children eligible for Medicaid via CHIP so they can be reported separately from children eligible for Medicaid via the 1902(r)(2) Medicaid State Plan Amendment. This will allow CHIP eligible children (optional targeted low-income children) to be reported and claimed at the enhanced rate, and other new eligible children to be reported and claimed at the State's Standard FMAP.

Children newly eligible for Medicaid **as** a result of the expansion will receive health care services through the same delivery systems that operate in the current Medicaid program.

The State understands that this initial State CHIP Plan submission secures the entire state allotment regardless of estimated budget for Medicaid expansion. The State reserves the right to submit a State CHIP Plan amendment at any time.

Section 2. General Background and Description of State Approach to Child Health Coverage (Section 2102 (a)(1)-(3)) and (Section 2105)(c)(7)(A)-(B))

2.1. Describe the extent to which, and manner in which, children in the state including targeted low-income children and other classes of children, by income level and other relevant factors, such as race and ethnicity and geographic location, currently have creditable health coverage (as defined in section 2110(c)(2)). To the extent feasible, make a distinction between creditable coverage under public health insurance programs and public-private partnerships (See Section 10 for annual report requirements).

Historically, Iowa is a rural, agricultural state. However, recently there has been a shift in population from rural areas to urban centers. New estimates from the U.S. Census Bureau show that population growth in Iowa during the 1990's is confined to two areas: in and around Des Moines; and in the Cedar Rapids/Iowa City corridor. At the same time, 45 of Iowa's 99 counties are losing population. Data from 1994 suggests that 44 percent of Iowan's live inside a metropolitan area.

Population projections for Iowa, 1995, show 807,807 children (<19 years). The 1990 census put the total population of Iowa at 2,776,754. The most recent U.S. Census reports show 11.5% of Iowa's population living below poverty. In general, the highest levels of poverty are in the southern counties along the Missouri border. Applying the U.S. Census estimate to the 1996 population projection of 2.842 million residents, indicates there are approximately 326,830 residents with incomes below FPL (Federal Poverty Level).

While approximately 2,685,098 (96.6%) of Iowa's population are white and 47,259 (1.7%) are black, Iowa is experiencing an ever emerging diverse population:

Estimated Number of Refugees and Amerasians in Iowa

Region of Origin	No. Who Originally Settled in Iowa	No. Who Moved to Iowa After Originally Settling Elsewhere in U.S.
Africa Sudanese All Others	563 473	454 108
Middle/Near Iraqi All Others	East Asia 125 80 (Kurds)	23

Former Soviet Union		
All Ethnic Groups	401	11
Eastern Europe		
Bosnian	2,211	1,303
All Others	361 (Romanian, Polish, Hungarian)	12
Southeast Asia		
Vietnamese	7,001	2,046
Tai Dam	2,740	2 -
Lowland Lao	3,281	253
Cambodian/Khmer	840	17
Hmong	423	20
Latin America/Caribbea	an	
Haitian	21	
Cuban	5	5
Nicaragua		1
TOTAL	18,197	4,261

The Mksquaki Tribe is the only Federally recognized Native American Tribe in Iowa. It is a subset of the Sac and Fox of the Mississippi and Iowa Tribe and currently has 1,277 enrolled members. The improving economic conditions on the Mesquaki Settlement, primarily due to casino revenue, has resulted in a significant growth trend and a 200% birth rate increase since 1992. Approximately 37% of the Tribal members are under age 18.

The only public health insurance program generally available in Iowa is Medicaid. In March, 1998, there were 95,189 children (48,863 male / 46,326 female) receiving c 'erage through the Medicaid program. The State estimates that the expansion of Medicaid eligibility for all children under age 19, up to 133% of FPL will make an additional 15,600 children eligible for Medicaid coverage.

The Iowa Caring Program for Children a, primarily privately funded, Wellmark (Blue Cross Blue Shield of Iowa and South Dakota) sponsored program, currently covers about 3,000 children below 133% of FPL. This program covers uninsured children who do not qualify for Medicaid.

2.2. Describe the current state efforts to provide or obtain creditable health coverage, for uncovered children by addressing: (Section 2102)(a)(2)

2.2.1. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in public health insurance programs (i.e. Medicaid and state-only child health insurance):

Medicaid

The Medicaid program is the only public health insurance program for children in Iowa. Medicaid is administered through the Department of Human Services (DHS) Central Office in Des Moines and through 104 DHS offices (including the Refugee Services Center) located in all 99 counties. Additionally, outstationed eligibility workers are currently located at the following sites:

Broadlawns Hospital Des Moines
Marian Health Center Sioux City
St. Luke's Medical Center Sioux City

There are four Federally Qualified Health Centers (FQHC) in Iowa. Currently there are no outstationed eligibility workers at these sites.

Medicaid applications are readily available to anyone who requests one. Additionally, there is a toll-free number for anyone to call to ask questions about Medicaid eligibility and to find out where and how to apply. The number is **1-800-869-6334**.

In March, 1998, Iowa had 95,189 children with health care coverage through the Medicaid program. Eligibility for Medicaid continues to remain available for the following federal categories of children: Those who qualify because they would have been eligible for cash assistance prior to July 16, 1996, and related categorical programs; those who are in foster care and subsidized adoption; those who qualify for the Mothers and Children program (SOBRA); those who meet Medicaid disability criteria; those who are medically needy, and those who qualify under the following home and community based waivers:

	Enrollment Cap
 II1 and Handicapped Waiver 	700 (currently has a waiting list)
 Mental Retardation Waiver 	1,098 (currently has a waiting list)
Brain Injury Waiver	60
 AIDS Waiver 	150

Studies have shown that crowd out is more prevalent at income levels near or above 200% of the FPL. Since Iowa proposes only to expand Medicaid to 133% of the FPL, it is not anticipated that crowd out will be a significant issue among the expansion population. We anticipate that many of the children who will be covered through the expansion will be siblings of younger children who are already receiving coverage through Medicaid.

Health It surance Premium Payment Frogram (HIPP)

Iowa was one of the first states to implement the provisions of section **1906** of the Social Security Act which mandated states to purchase employer-related health insurance coverage for Medicaid-eligible persons when it was determined cost-effective to do so. Iowa implemented the Health Insurance Premium Payment (HIPP) program on July **1,1991**. Although section **1906** of the Social Security Act has now become optional, Iowa continues to maintain a strong HIPP program. Although this program is primarily designed to reduce Medicaid expenditures by providing a third party resource for Medicaid-eligible persons, oftentimes it is cost-effective to purchase family coverage which results in providing coverage for the non-Medicaid-eligible household members **as** well. By initiating coverage while on Medicaid, families have coverage in place when they leave the Medicaid roles.

<u>Direct Health Services (Title V, Title X, WIC, etc.)</u>

The Iowa Department of Public Health (IDPH) is the largest single provider of direct as well as support patient care for uninsured and Medicaid enrolled children and adolescents. Direct services for this population include: preventive child health services (EPSDT and well-child check-ups), prenatal services, Women, Infants and Children Supplemental Nutrition [WIC] program services, preventive health education, immunizations, and family planning services. Support services include case coordination services, the provision of information and referral via toll-free telephone lines, and laboratory services. These services are funded through federal Title V Maternal and Child Health Block Grant funds, federal Title X Family Planning program funds, federal WIC Program funds, Medicaid program reimbursements, federal immunization funds, state legislative appropriations, some local government appropriations, and a small amount of patient fee revenue collected on a sliding fee scale by Title V agencies. A variety of the above direct and support services are provided within each of the 99 Iowa counties. Twentysix Ma nal Health Centers and twenty Child Health Centers provide statewide services. Adolescent services are provided in 25 locations in the state.

Additionally, there are approximately 486 full-time school health nurses working under the auspices of the Iowa Department of Education and local education agencies in the state who provide a variety of health screening services, care coordination and emergency services.

Income assessments are performed on patients enrolled in IDPH clinics. The income assessments are reviewed for possible Medicaid eligibility. New applications, as well as arrual reviews of established patients, are assessed by , IDPH intake staff andor care coordinators for possible referral for medical assistance through Medicaid andor SSI.

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In order to provide additional outreach, the IDPH operates two toll-free telephone lines for use by the general public. The toll-free telephone lines are known as Healthy Families and Teen Line. These are information and referral services for health issues. The Healthy Families line addresses a wide variety of health issues with special emphasis on prenatal care. The Teen Line also addresses a wide variety of issues specifically related to the health of teenagers. Topics covered include drugs, sexual relationships, eating disorders, relationships with parents, and violence. Two integral parts of the information provided to callers, via these telephone lines, are information on Medicaid eligibility and referrals to community based care coordinators who can assist clients with locating local health providers who accept Medicaid-eligible children and Medicaid-eligible pregnant women. The toll-free number for Healthy Families is 1-800-369-2229. The Teen Line number is 1-800-443-8336. Both lines are operational 24 hours a day, seven (7) days a week.

Child Health Specialty Clinics

Each year, approximately 5,500 Iowa children receive services at the Child Health Specialty Clinics (CHSC), through the University of Iowa Hospitals and Clinics. The Department of Human Services has an interagency cooperation agreement with the CHSC which serve as a link between major medical centers and the community by assisting families to obtain needed resources. The CHSC serves children from birth to 22 years with or at risk of a chronic health condition or disability which includes psychosocial, physical, health-related educational, and behavioral needs. The specific health concerns may be simple or complex, short-term or long-term.

Small Group Insurance Reform

Iowa enacted small group reforms in 1992. These reforms provided more affordable coverage for the small employer group market, thus allowing employees and their dependents to obtain coverage at more affordable rates. The reforms included limitations on rate increases as well as limitations on pre-existing condition clauses.

In 1996, Iowa implemented individual market reforms which provide for portability for employees and their dependents from a group to the individual market, as well as rating restrictions on individual products.

State High Risk Insurance Pool

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Iowa law establishes a state administered high-risk health insurance program for those individuals and their dependents who cannot obtain coverage in the private market. This program is funded by a 2% tax on health insurance premiums. Persons who are eligible for Medicaid or COBRA continuation coverage are not eligible to participate in this program. Coverage in the high risk program provides portability for individuals to the private market.

2.2.2. The steps the state is currently taking to identify and enroll all uncovered children who are eligible to participate in health insurance programs that involve a public private partnership:

The Caring Program for Children

There is only one health insurance program in Iowa that resembles a public-private partnership. However, it is not administered by the State. This program is known as the Caring Program for Children and is administered by Wellmark, (Blue Cross and Blue Shield of Iowa and South Dakota). The Iowa Caring Foundation provides ambulatory health insurance to low income, non-Medicaid/uninsured children under the age of 19 years who remain full-time students through grade 12. Funded through a state appropriation and private donations, with matching funds from Wellmark, the Caring Foundation is in its 10th year of operation and currently has over 3000 children enrolled. Outreach for this program is conducted through articles in Wellmark publications and public service announcements in local newspapers, via television, and radio stations. Case finding is conducted by school administrators, school nurses, and day care operators. Additionally referrals to the Foundation are received from Department of Public Health, the Iowa Department of Human Services, the individual health care providers, civic organizatioi. churches, Sunday School classes, other religious organizations, and from Foundation participants.

The proposed Medicaid expansion will result in children who were previously ineligible for Medicaid and who are currently participating in the Caring Program, transferring to Medicaid. The Department of Human Services and the Caring Program have begun to develop a work plan to transition these children into Medicaid. The transition will consist of the Department of Human Services providing Medicaid applications and brochures to the Caring Program for dissemination to their participants. The Caring Program will follow-up to ensure that Medicaid eligibility has been attained before canceling coverage. The Caring Program estimates this transition will take two to four months. The future of the Caring Program for Children has not been determined. However, it is anticipated

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they will maintain their role in some capacity as a "safety-net" insurer for children who do not qualify for Medicaid.

2.3. Describe how the new State Title XXI program(s) is(are) designed to be coordinated with such efforts to increase the number of children with creditable health coverage so that only eligible targeted low-income children are covered:

(Section 2102)(a)(3)

The Medicaid program will be expanded to include children up to the age of 19 at financial eligibility levels up to 133% of the federal poverty level. Studies have shown that there is no significant "crowd-out" at these income levels. If experience proves that "crowd-out" is significant, the State will develop strategies to address it.

In preparing the budget for the enrollment of the additional children, the Division of Medical Services does not anticipate the need to hire any additional Medicaid eligibility workers. Workers in all 99 counties will enroll children who are eligible for Medicaid under current eligibility rules as well as those who are eligible for the Medicaid expansion.

Information regarding the expanded eligibility will be widely disseminated through out the State. In addition to the training of eligibility workers about the new limits, an article will be published in "*The Difference*" which is a quarterly news letter for clients and advocates.

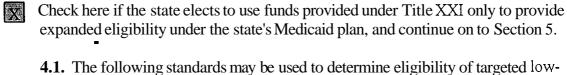
Section 3. General Contents of State Child Health Plan (Section 2102)(a)(4))



Check here if the state elects to use funds provided under Title XXI **only** to provide expanded eligibility under the state's Medicaid plan, and continue on to Section **4.**

- 3.1. Describe the methods of delivery of the child health assistance using Title XXI funds to targeted low-income children: (Section 2102)(a)(4)
- 3.2. Describe the utilization controls under the child health assistance provided under the plan for targeted low-income children: (Section 2102)(a)(4)

Section 4. Eligibility Standards and Methodology. (Section 2102(b))



- income children for child health assistance under the plan. Please note whether any of the following standards are used and check all that apply. If applicable, describe the criteria that will be used to apply the standard. (Section 2102)(b)(1)(A))

 4.1.1. Geographic area served by the Plan:
 - **4.1.2.** 4ge:
 - **4.1.3.** Income:
 - **4.1.4.** Resources (including any standards relating to spend downs and disposition of resources):
 - **4.1.5. Residency**:
 - **4.1.6.** Disability Status (so long **as** any standard relating to disability status does not restrict eligibility):
 - **4.1.7.** Access to or coverage under other health coverage:

- **4.1.8.** Duration of eligibility:
- **4.1.9.** Other standards (identify and describe):
- 4.2. The state assures that it has made the following findings with respect to the eligibility standards in its plan: (Section 2102)(b)(1)(B))
- **4.2.1.** These standards do not discriminate on the basis of diagnosis.
- **4.2.2.** Within **a** defined group of covered targeted low-income children, these standards do not cover children of higher income families without covering children with a lower family income.
- **4.2.3.** These standards do not deny eligibility based on a child having a pre-existing medical condition.
- **4.3.** Describe the methods of establishing eligibility and continuing enrollment.

(Section 2102)(b)(2))

- **4.4.** Describe the procedures that assure:
- **4.4.1.** Through intake and follow up screening, that **only** targeted low-income children who are ineligible for either Medicaid or other creditable coverage are furnished child health assistance under the state child health plan. (Section 2102)(b)(3)(A))
- 4.4.2. That children found through the screening to be eligible for medical assistance under the state Medicaid plan under Title XIX are enrolled for such assistance under such plan. (Section 2102)(b)(3)(B))
- 4.4.3. That the insurance provided under the state child health plan does not substitute for coverage under group health plans. (Section 2102)(b)(3)(C))
- **4.4.4.** The provision of child health assistance to targeted low-income children in the state who are Indians (as defined in section 4 0 of the Indian Health Care Improvement Act, 25 U.S.C. 1603(c). (Section 2102)(b)(3)(D))

4.4.5. Coordination with other public and private programs providing creditable coverage for low-income children. (Section 2102)(b)(3)(E)) 14

Section 5. Outreach and Coordination (Section 2102(c))

Describe the procedures used by the state to accomplish:

5.1. Outreach to families of children likely to be eligible for assistance or under other public or private health coverage to inform them of the availability of, and to assist them in enrolling their children in such a program: (Section 2102(c)(1))

This section consists solely **of** efforts targeted toward Medicaid eligible children from birth through age 18. There are three primary avenues through which outreach will be conducted initially. These avenues are (1) the use of existing outreach approaches, especially an intensive effort to reach previously ineligible children in families with other Medicaid covered children, and families that did not qualify based on income prior to the expansion; (2) an initiative to improve communication with schools and community agencies, such **as** Title V Maternal and Child health Centers, Head **Start** programs, child care centers, United Way agencies, etc. which come in frequent contact with potentially eligible children; and (3) coordination with medical providers to educate them and their potentially eligible patients. These avenues **are** described in more detail below.

Current Outreach Approaches

As presented in section 2.2.1 of this application, activities to promote the enrollment of eligible children in the Medicaid program and health clinics are conducted by several state agencies through a variety of means. Please refer to section 2.2.1 for a detailed description of these outreach activities. The current outreach methodologies will be updated so that older children and middle and older teens are included in the population targeted by these efforts. The state also intends to implement an outreach plan which will involve community education to providers and others who serve children. On May 14,1998, a Request for Proposal (RFP) was released to contract for the development and implementation of an outreach program (see Attachments for a copy of the RFP). Through this contract, the Iowa Department of Human Services plans to provide education to provider associations, state agencies (e.g. Department of Human Rights, Commission for the Blind, Division of Deaf Services, etc.), and advocacy groups such as Native American Tribal Councils, Hispanic and African American organizations, and refugee resettlement programs. Applications will also be available for distribution by these groups.

A notice to the parents of current recipients will serve to inform them of the potential eligibility of their older children who are siblings of current Medicaid recipients. A notice will also be sent to all persons who are denied Medicaid in the **60** days prior to the effective date of the expansion to inform them of the change in the eligibility rules.

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The Iowa Departments of Human Services and Public Health, in collaboration with the Caring Foundation for Children, have applied for the "Covering Kids: A National Health Access Initiative for Low-Income, Uninsured Children" grant being offered through the Robert Wood Johnson Foundation. This grant will award states \$500,000 to \$1,000,000 to develop outreach programs that will increase the number of eligible children in health insurance programs. The purpose of the initiative is to facilitate efforts to:

- design and conduct outreach programs that identify and enroll eligible children into Medicaid and other coverage programs;
- simplify enrollment processes; and
- coordinate existing coverage programs for low-income children.

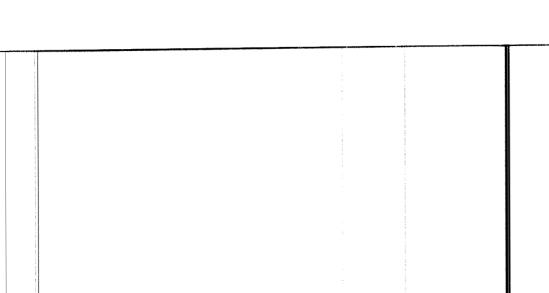
If Iowa is awarded this grant, the focus will be on community-based outreach programs.

In addition to the outreach activities aimed at enrolling eligible children, the state agencies' existing efforts to promote the use of health care services and continuity **of** care will also be expanded to include the new Title XXI enrollees. These activities include use of the media, case management and patient follow-up systems (especially within the Title V, Title X and Title XX Block Grant Programs, and related programs for children within the Iowa Department of Human Services.

Case management consists of a variety of activities designed to identify an individual patient's psychosocial needs and barriers to obtaining health services (such **as** enrolling in Medicaid), and assist the patient in meeting those needs and accessing services. Patient follow-up includes a variety of activities designed to ensure that patients comply with the recommendations of their health care provider(s) and continue in the health care system.

One example of Iowa's continuing effort to improve the health status of school-aged children, the Project Success Program, coordinates social and health services w...h parental involvement in 13 designated school sites in the Des Moines school district. Project Success sites, which include seven elementary schools, two middle schools, two high schools, and two alternative high schools, refer potentially eligible Medicaid children for eligibility determination. Additionally, sixteen school based/linked clinics provide services to school-aged children, their siblings and preschool aged children in the district. The clinics are required to assess income levels and refer those children who appear to be Medicaid eligible for eligibility determination while at the same time providing needed medical services.

5.2. Coordination **of** the administration of this program with other public and private health insurance programs: (Section 2102(c)(2))



Services are provided at Federally Qualified Health Centers (FQHCs) and disproportionate share hospitals through out the state.									
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As described in Section 2, Medicaid is the only public health insurance program in

Iowa.

Section 6. Coverage Requirements for Children's Health Insurance (Section 2103)



Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 7.

6.1. The state elects to provide the following forms of coverage to children:

(Check all that apply.)

- **6.1.1.** Benchmark coverage; (Section 2103(a)(1))
 - **6.1.1.1.** FEHBP-equivalent coverage; (Section 2103(b)(1)) (If **checked**, **attach copy of the plan**.)
 - **6.1.1.2.** State employee coverage; (Section 2103(b)(2)) (If checked, identify the plan and attach a copy of the benefits description.)
 - **6.1.1.3. HMO** with largest insured commercial enrollment (Section 2103(b)(3)) (If checked, identify the plan and attach a copy of the benefits description.)
- **6.1.2.** Benchmark-equivalentcoverage; (Section 2103(a)(2)) Specify the coverage, including the amount, scope and duration of each service, as well as any exclusions or limitations. Please attach signed actuarial report that meets the requirements specified in Section 2103(c)(4). See instructions.
- **6.1.3.** Existing Comprehensive State-Based Coverage; (Section 2103(a)(3)) **[Only** applicable to New York; Florida; Pennsylvania] Please attach a 'escription of the benefits package, administration, date of enactment. "existing comprehensive state-based coverage" is modified, please provide an actuarial opinion documenting that the actuarial value of the modification is greater than the value **as** of 8/5/97 or one of the benchmark plans. Describe the fiscal year 1996 state expenditures for "existing comprehensive state-based coverage."
- **6.1.4.** Secretary-Approved Coverage. (Section 2103(a)(4))
- **6.2.** The state elects to provide the following forms of coverage to children:

(Check all that apply. If an item is checked, describe the coverage with respect to the amount, duration and scope of services covered, as well as any exclusions or limitations) (Section 2110(a))

Inpatient services (Section 2110(a)(1)) **6.2.2.** Outpatient services (Section 2110(a)(2)) 6.2.3. Physician services (Section 2110(a)(3)) **6.2.4.** Surgical services (Section 2110(a)(4)) 6.2.5. Clinic services (including health center services) and other ambulatory health care services. (Section 2110(a)(5)) Prescription drugs (Section 21 10(a)(6)) **6.2.6.** 6.2.7. Over-the-counter medications (Section 2110(a)(7)) **6.2.8.** Laboratory and radiological services (Section 21 10(a)(8)) 6.2.9. Prenatal care and prepregnancy family services and supplies (Section 2110(a)(9)) Inpatient mental health services, other than services described in **6.2.10.** 6.2.18., but including services furnished in a state-operated mental hospital and including residential or other 24-hour therapeutically planned structural services (Section 2110(a)(10)) 6.2.11. Outpatient mental health services, other than services described in 6.2.19, but including services furnished in a state-operated mental hospital and including community-based services (Section 2110(a)(11) **6.2.12**. Durable medical equipment and other medically-related or remedial devices (such as prosthetic devices, implants, eyeglasses, hearing aids, dental devices, and adaptive devices) (Section 2110(a)(12)) 6.2.13. Disposable medical supplies (Section 2110(a)(13)) **6.2.14.** Home and community-based health care services (See instructions) (Section 2110(a)(14)) **6.2.15**. Nursing care services (See instructions) (Section 2110(a)(15))

2110(a)(16)

6.2.16. Abortion **only** if necessary to save the life of the mother or if the

pregnancy is the result of an act of rape or incest (Section

6.2.17. Dental services (Section 2110(a)(17))

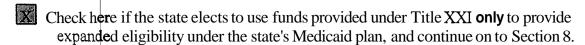
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- **6.2.18.** Inpatient substance abuse treatment services and residential substance abuse treatment services (Section 2110(a)(18))
- **6.2.19.** Outpatient substance abuse treatment services (Section 2110(a)(19))
- **6.2.20.** Case management services (Section 2110(a)(20))
- **6.2.21**. Care coordination services (Section **2**110(a)(21))
- **6.2.22.** Physical therapy, occupational therapy, and services for individuals. with speech, hearing, and language disorders (Section 2110(a)(22))
- **6.2.23**. Hospice care (Section 2110(a)(23))
- **6.2.24.** Any other medical, diagnostic, screening, preventive, restorative, remedial, therapeutic, or rehabilitative services. (See instructions) (Section 2110(a)(24))
- 6.2.25. Premiums for private health care insurance coverage (Section 2110(a)(25))
- **6.2.26**. Medical transportation (Section 2110(a)(26))
- **6.2.27.** Enabling services (such **as** transportation, translation, and outreach services (See instructions) (Section 2110(a)(27))
- **6.2.28.** Any other health care services or items specified by the Secretary and not included under this section (Section 2110(a)(28))
- 6.3. Waivers Additional Purchase Options. If the state wishes to provide services under the plan through cost effective alternatives or the purchase of family coverage, it must request the appropriate waiver. Review and approval of the waiver application(s) will be distinct from the state plan approval process. To be approved, the state must address the following: (Section 2105(c)(2) and(3))
 - 6.3.1. Cost Effective Alternatives. Payment may be made to a state in excess of the 10% limitation on use of funds for payments for: 1) other child health assistance for targeted low-income children; 2) expenditures for health services initiatives under the plan for improving the health of children (including targeted low-income children and other low-income children); 3) expenditures for outreach activities as provided in section 2102(c)(1) under the plan; and 4) other reasonable costs

incurred by the state to administer the plan, if it demonstrates the following:

- 6.3.1.1. Coverage provided to targeted low-income children through such expenditures must meet the coverage requirements above; Describe the coverage provided by the alternative delivery system. The state may cross reference section 6.2.1 6.2.28. (Section 2105(c)(2)(B)(I))
- 6.3.1.2. The cost of such coverage must not be greater, on an average per child basis, than the cost of coverage that would otherwise be provided for the coverage described above; and Describe the cost of such coverage on an average per child basis. (Section 2105(c)(2)(B)(ii))
- 6.3.1.3. The coverage must be provided through the use of a community-based health delivery system, such as through contracts with health centers receiving funds under section 330 of the Public Health Service Act or with hospitals such as those that receive disproportionate share payment adjustments under section 1886(d)(5)(F) or 1923 of the Social Security Act. Describe the community based delivery system. (Section 2 105(c)(2)(B)(iii))
- Purchase of Family Coverage. Describe the plan to provide family coverage. Payment may be made to a state for the purpose of family coverage under a group health plan or health insurance coverage that includes coverage of targeted low-income Children, if it demonstrates the following: (Section 2105(c)(3))
 - 6.3.2.1. Purchase of family coverage is cost-effective relative to the amounts that the state would have paid to obtain comparable coverage only of the targeted low-income children involved; and (Describe the associated costs for purchasing the family coverage relative to the coverage for the low income children.) (Section 2105(c)(3)(A))
 - 6.3.2.2. The state assures that the family coverage would not otherwise substitute for health insurance coverage that would be provided to such children but for the purchase of family coverage. (Section 2105(c)(3)(B))

Section 7. Quality and Appropriateness of Care



7.1. Describe the methods (including external and internal monitoring) used to assure the quality and appropriateness of care, particularly with respect to well-baby care, well-child care, and immunizations provided under the plan. (2102(a)(7)(A))

Will the state utilize any of the following tools to assure quality? (Check all that apply and describe the activities for any categories utilized.)

- **7.1.1.** Quality standards
- **7.1.2.** Performance measurement
- **7.1.3**. Information strategies
- **7.1.4.** Quality improvement strategies
- **7.2.** Describe the methods used, including monitoring, to assure access to covered services, including emergency services. (2102(a)(7)(B))

Section 8. Cost Sharing and Payment (Section 2103(e))

X	Check here if the state elects to use funds provided under Title XXI only to provide expanded eligibility under the state's Medicaid plan, and continue on to Section 9.
8.1.	Is cost-sharing imposed on any of the children covered under the plan?
	8.1.1. YES
	8.1.2. NO, skip to question 8.5.
8.2.	Describe the amount of cost-sharing and any sliding scale based on income: (Section 2103(e)(1)(A))
	8.2.1. Premiums:
	8.2.2. Deductibles:
	8.2.3. Coinsurance:
	8.2.4 . Other:
8.3.	Describe how the public will be notified of this cost-sharing and any differences based on income:
8.4.	The state assures that it has made the following findings with respect to the cost sharing and payment aspects of its plan: (Section 2103(e))
	8.4.1. Cost-sharing does not favor children from higher income families over lower income families. (Section 2103(e)(1)(B))
	8.4.2. No cost-sharing applies to well-baby and well-child care, including age-appropriate immunizations. (Section 2103(e)(2))
	8.4.3. No child in a family with income less than 150% of the Federal Poverty Level will incur cost-sharing that is not permitted under 19 16(b)(1).
	8.4.4. No Federal funds will be used toward state matching requirements. (Section 2105(c)(4))
	8.4.5. No premiums or cost-sharing will be used toward state matching requirements. (Section 2105(c)(5)
	8.4.6. No funds under this title will be used for coverage if a private insurer would have been obligated to provide such assistance except for a

provision limiting this obligation because the child is eligible under the this title. (Section 2105(c)(6)(A))

- 8.4.7. Income and resource standards and methodologies for determining Medicaid eligibility are not more restrictive than those applied as of June 1, 1997. (Section 2105(d)(1))
- 8.4.8. No funds provided under this title or coverage funded by this title will include coverage of abortion except if necessary to save the life of the mother or if the pregnancy is the result of an act of rape or incest. (Section 2105)(c)(7)(B))
- **8.4.9.** No funds provided under **this** title will be used to pay for any abortion or to assist in the purchase, in whole or in part, for coverage that includes abortion (except **as** described above). (Section 2105)(c)(7)(A))
- **8.5.** Describe how the state will ensure that the annual aggregate cost-sharing for a family does not exceed 5 percent of such family's annual income for the year involved: (Section 2103(e)(3)(B))
- **8.6.** The state assures that, with respect to pre-existing medical conditions, one of the following two statements applies to its plan:
 - **8.6.1**. The state shall not permit the imposition of any pre-existing medical condition exclusion for covered services (Section 2102(b)(1)(B)(ii)); OR
 - 8.6.2. The state contracts with a group health plan or group health insurance coverage, or contracts with a group health plan to provide family coverage under a waiver (see Section 6.3.2. of the template). Pre-existing medical conditions are permitted to the extent allowed by HIPA VERISA (Section 2109(a)(1),(2)). Please describe:

Section 9. Strategic Objectives and Performance Goals for the Plan Administration (Section 2107)

9.1. Describe strategic objectives for increasing the extent of creditable health coverage among targeted low-income children and other low-income children: (Section 2107(a)(2))

Objective One:

Increase the health status of children in Iowa.

Objective Two:

Increase the number of children who have access to heath

care.

Objective Three:

Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g.

asthma).

Objective Four:

Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in

another medical setting.

Objective Five:

All children participating in the program will have a

medical home.

9.2. Specify one or more performance goals for each strategic objective identified: (Section 2107(a)(3))

Objective One:

Increase the health status of children in Iowa.

• By July 1,1998, the capacity within the Iowa Department of Human Services, in the following critical areas, will be appropriately upgraded to meet the target of enrolling approximately 15,600 additional children in the Medicaid program in state fiscal year 1999: (1) upgrading data systems with regard to eligibility determination, enrollment, participant information, health service utilization, billing, health status, provider information, etc.; (2) staff training (eligibility workers, administrative staff, and support staff),(3) publications/documents (program manuals, literature for program personnel, consumers and providers, etc.)

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- By January 1,2000, the following health status and health care system measures will show acceptable incremental improvements for at least the following:
- 1. Seventy-five percent of enrolled children will be appropriately immunized at age two, excluding varicella immunizations. A base line rate for comparison for varicella will be established by a clinical advisory committee.
- 2. Eighty percent **of** enrolled children will participate in EPSDT and receive a well-child visit, **as** measured by the **HCFA 416 (Armual** EPSDT Participation Report) participation ratio.
- **3.** Eighty percent of enrolled children will have received at least one preventive dental visit annually.
- **4.** The rate of enrolled pregnant teens who deliver a very low birth weight baby will be lower than that of a comparable baseline population.

Objective Two:

Increase the number of children who have access to health care.

• By January 1,1999, mechanisms to conduct ongoing outreach will have been developed and implemented in four broad areas (1) update/expansion of existing outreach activities; (2) activities to identify, enroll, and serve Iowa's growing qualified refugee and immigrant population; (3) at least 15,000 previously uninsured children will be identified as potential eligibles; (4) by January 1, 1999, 10,000 (2/3 of the eligibles) previously uninsured low-income children will have health insurance coverage through the Medicaid program.

Objective Three:

Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g. asthma).

• Percent of children admitted as inpatients for asthma.

Objective Four:

Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting (e.g. otitis media).

• Reduce the number of emergency room visits for treatment of non-emergent medical conditions.

Objective Five:

All children participating in the program will have a medical home.

- By February 1, 1999, at least 50% of those children enrolled (except those exempted from participation in managed care such as children in foster care) will have a medical home as evidenced by documented assignment of a provider through the MediPASS program or a Medicaid HMO.
- 9.3. Describe how performance under the plan will be measured through objective, independently verifiable means and compared against performance goals in order to determine the state's performance, taking into account suggested performance indicators as specified below or other indicators the state develops:

(Section 2107(a)(4)(A),(B))

Assurance of an Objective Means for Measuring Performance

Iowa will measure performance by establishing a baseline for each performance goal through various methods including: conducting a baseline population-based survey; using State vital records, hospital discharge and claims information; and using other Medicaid and non-Medicaid data bases that provide relevant information. For each performance goal, the method of measurement will be established and reports will be generated to monitor, on an ongoing basis, Iowa's progress toward meeting the goal.

Objective One:

Increase the health status of children in Iowa.

Measurement & Performance:

- Training Documentation that 100% of eligibility workers, administrative staff and outreach/case managers responsible for any aspect of implementation of the program, have received training regarding the program and their implementation responsibilities.
- Publications/Documents 100% of program manuals and literature for program personnel, literature for consumers and literature for providers will contain up-to-date information (as appropriate to the document) regarding the program, its rules and regulations, and pertinent

- departmental policies; will be written at appropriate grade levels; and will reach potential eligibles and providers.
- Effectiveness of care adolescent immunization status 80% of 16-year-olds who receive all appropriate immunizations, including tetanus boosters, by their 16th birthday.
- Adolescent health promotion counseling 80% of 16-yearolds who receive health promotion counseling/education by their 16th birthday.
- Number of middle and older adolescents, aged **14-**18 years, during the reporting period who had at least one comprehensive well-child visit with a primary care provider during the reporting year.
- Number of children who had at least one preventive dental visit during the reporting year.
- Number of children under age two who are appropriately immunized.

Objective Two:

Increase the number of children who have access to health care.

Measurement of Performance:

- Outreach identification of eligible children At least 15,000 children will be assessed for eligibility in Iowa's expanded Medicaid program during Year I.
- Insurance Coverage/Expansion of coverage Provision of Medicaid coverage to previously uncovered children At least 10,000 previously uninsured, low-income children will be enrolled in Iowa expanded Medicaid program during Year I.

Objective Three:

Reduce the instances of hospitalization for medical conditions that can be treated with routine care (e.g. asthma).

Measurement of Performance:

• Percent of children admitted **as** inpatients for asthma.

Objective Four:

Reduce the instances of emergency room visits for treatment of a medical condition that could be treated in another medical setting.

Measurement of Performance:

 Percent of children treated in an emergency room setting.

Objective Five:

All children participating in the program will have a medical home.

Measurement & Performance

• One primary medical provider (**or** provider site) for each enrollee. Documentation of assignment of a primary medical provider to each child enrolled in Phase I of the program.

Check the applicable suggested performance measurements listed below that the state plans to use: (Section 2107(a)(4))

- **9.3.1.** The increase in the percentage of Medicaid-eligible children enrolled in Medicaid.
- **9.3.2.** The reduction in the percentage of uninsured children.
- **9.3.3.** The increase in the percentage **of** children with a usual source **of** care.
- **9.3.4.** The extent to which outcome measures show progress on one or more of the health problems identified by the state.
- **9.3.5.** HEDIS Measurement Set relevant to children and adolescents younger than 19.
- **9.3.6.** Other child appropriate measurement set. List or describe the set used.
- **9.3.7.** If not utilizing the entire HEDIS Measurement Set, specify which measures will be collected, such as:
- **9.3.7.1.** Immunizations
- **9.3.7.2. X** Well child care
- **9.3.7.3.** Adolescent well visits
- **9.3.7.4.** Satisfaction with care

9.3.7	.5.	Mental health
9.3.7	.6. X	Dental care
9.3.7	.7.	Other, please list:
9.3.8	•	Performance measures for special targeted populations.
9.4.	the Secr	assures it will collect all data, maintain records and furnish reports to etary at the times and in the standardized format that the Secretary (Section 2107(b)(1))
9.5.	required	e assures it will comply with the arrual assessment and evaluation under Section 10.1. and 10.2. (See Section 10) Briefly describe the an for these arrual assessments and reports. (Section 2107(b)(2))
	Manage under the for this I Public P data and care, and	the has an approved Section 1915(b) waiver for Primary Care Case ment (PCCM). The State is responsible for assessment and evaluation the PCCM waiver and intends to use the same investigator and contract Medicaid expansion as used for the PCCM. The investigator (the Policy Center at the University of Iowa) will have access to Medicaid I can develop measures such as number of office visits, continuity of the hospitalizations that would compare the newly enrolled group to the yexisting Medicaid population.
9.6.		e assures it will provide the Secretary with access to any records or tion relating to the plan for purposes of review of audit. (Section (3))
9.7.	The stat those m develop	±
9.8. X	Social S	the assures, to the extent they apply, that the following provisions of the Security Act will apply under Title XXI, to the same extent they apply the under Title XIX: (Section 2107(e))

limitations on payment)

and taxes)

Section 1902(a)(4)(C) (relating to conflict of interest standards)

Section 1903(w) (relating to limitations on provider donations

Paragraphs (2), (16) and (17) of Section 1903(I) (relating to

9.8.1. X

9.8.2. X

9.8.3. X

- **9.8.4.** Section 1115 (relating to waiver authority)
- **9.8.5.** Section 1116 (relating to administrative and judicial review), but only insofar **as** consistent with Title XXI
- **9.8.6.** Section 1124 (relating to disclosure of ownership and related information)
- **9.8.7.** Section 1126 (relating to disclosure of information about certain convicted individuals)
- **9.8.8.** Section 1128A (relating to civil monetary penalties)
- **9.8.9.** Section 1128B(d) (relating to criminal penalties for certain additional charges)
- **9.8.10.** Section 1132 (relating to periods within which claims must be filed)
- **9.9.** Describe the process used by the state to accomplish involvement of the public in the design and implementation **of** the plan and the method for insuring ongoing public involvement. (Section 2107(c))

Efforts have been made to make the process of developing the design and implementation of the Children's Health Insurance Program an open one. In Iowa, the State Health Care Reform Strategy Group gave the Division of Medical Services the task of developing options as to how the SCHIP legislation could be developed. A Task Force was appointed to gather input from a wide array of interested parties. It was determined that gathering input from Iowa citizens was critical in developing program options. Eighteen public forums were scheduled in nine communities throughout the state. The media, direct mailings, and the distribution of over 70,000 flyers statewide were used to notify citizens and interest groups of the forums. Additionally, a toll-free telephone number, a fax line, and an e-mail site were established to gather input from persons who could not attend the forums. See **Attachment C, Report of the SCHIP Task Force.** The SCHIP Task Force was comprised of representatives of the:

- Governor's Office
- Iowa Insurance Division
- Iowa Department of Public Health
- Iowa Department of Personnel
- Iowa Department of Human Services
- Iowa Department of Education
- Legislative Fiscal Bureau
- Legislative Service Bureau
- Caring Foundation
- Cass County Mem. Hospital
- Visiting Nurses of Dubuque
- Iowa Assoc. of School Boards

- Iowa Department of Management
- Iowa House of Representatives
- Iowa Senate
- Drake Center for Health Issues
- Scott County Decategorization Project
- Iowa School Nurse Organization
- Parent Teacher Association
- Principal Financial Group
- American Republic Insurance
- Academy of Family Practitioners
- University of Iowa College of Medicine
- Iowa Chapter of American Pediatrics
- Medical Assistance Advisory Council
- **9.10.** Provide a budget for this program. Include details on the planned use of funds and sources of the non-Federal share of plan expenditures. (Section 2107(d))

1. Benefit expenditures (Medicaid expansion)	\$11,944,664
2. Administrative expenditures	\$ 656,904
3. Outreach	\$.500,000
Total SFY 1999 program expenditures	\$13,101,568
Total SFY 1999 program expenditures 3. Federal share (74.63%)	\$13,101,568 \$9,777,700

Section 10. Annual Reports and Evaluations (Section 2108)

- **10.1.** Annual Reports. The state assures that it will assess the operation of the state plan under this Title in each fiscal year, including: (Section 2108(a)(1),(2))
 - 10.1.1. The progress made in reducing the number of uncovered low-income children and report to the Secretary by January 1 following the end of the fiscal year on the result of the assessment, and
 - **10.1.2.** Report to the Secretary, January 1 following the end of the fiscal year, on the result of the assessment.

Below is a **chart** listing the types of information that the state's **annual** report might include. Submission of such information will allow comparisons to be made between states and on a nationwide basis.

	N 1 00111 12		T TOTAL T
Attributes of	Number of Children with	Number of Children	TOTAL
Population .	Creditable Coverage XIX OTHER CHIP	without Creditable	
	AIX OTHER CHIP	Coverage	
Income Level:		<u> </u>	İ .
< 100% -			
< 133%			
< 185%			
< 200%			
> 200%			
Age			
0 - 1			
1 - 5			
6 - 12			
13 - 18			
Race and			
Ethnicity			
American			
Indian or			
Alaskan Native			
Asian or			
Pacific Islander			
Black, not of			
Hispanic origin			
Hispanic			
White, not of Hispanic origin			
Location			
MSA			
Non-MSA			

- 10.2. State Evaluations. The state assures that by March 31,2000 it will submit to the Secretary an evaluation of each of the items described and listed below: (Section 2108(b)(A)-(H))
 - An assessment of the effectiveness of the state plan in increasing the number of children with creditable health coverage.
 - **10.2.2.** A description and analysis of the effectiveness of elements of the state plan, including:
 - The characteristics of the children and families assisted under the state plan including age of the children, family income, and the assisted child's access to or coverage by other health insurance prior to the state plan and after eligibility for the state plan ends;
 - **10.2.2.2.** The quality of health coverage provided including the types of benefits provided;
 - 10.2.2.3. The amount and level (including payment of part or all of any premium) of assistance provided by the state;
 - **10.2.2.4.** The service area of the state plan;
 - **10.2.2.5.** The time limits for coverage of a child under the state plan;
 - 10.2.2.6. The state's choice of health benefits coverage and other methods used 'or providing child health assistance, and
 - **10.2.2.7.** The sources of non-Federal funding used in the state plan.
 - **10.2.3.** An assessment of the effectiveness of other public and private programs in the state in increasing the availability of affordable quality individual and family health insurance for children.
 - 10.2.4. A review and assessment of state activities to coordinate the plan under this Title with other public and private programs providing health care and health care financing, including Medicaid and maternal and child health services.

- **10.2.5. An** analysis of changes and trends in the state that affect the provision of accessible, affordable, quality health insurance and health care to children.
- **10.2.6.** A description of any plans the state has for improving the availability of health insurance and health care for children.
- **10.2.7.** Recommendations for improving the program under this Title.
- **10.2.8.** Any other matters the state and the Secretary consider appropriate.
- **10.3.** The state assures it will comply with **future** reporting requirements **as** they are developed.
- **10.4.** The state assures that it will comply with all applicable Federal laws and regulations, including but not limited to Federal grant requirements and Federal reporting requirements.

Iowa Department of Human Services Division of Human Services 5th Floor, Hoover Building Des Moines, Iowa 50309-0114 05/21/98 4:27 PM

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ATTACHMENTS

COVERAGE AND CONDITIONS OF ELIGIBILITY

Citation(s)	Groups Covered
	A. Mandatory Coverage - Categorically Needy and Other Required Special Groups (Continued)
1902 (a) (10) (A) (i) (IV) and 1902 (l) (1) (A) and (B) of the Act	8. Pregnant women and infants under 1 year of age with family incomes up to 133 percent of the federal poverty level who are described in section 1902 (a) (10) (A) (I) (IV) and 1902 (1) (1) (A) and (B) of the Act. The income level for this group is specified in <u>Supplement 1 to Attachment 2.6-A</u> .
•	The state uses a percentage greater than 133 but not mor than 185 percent of the Federal poverty level, as established in its State plan, State legislation, or State appropriations as of December 19, 1989.
1902(a) (10) (A) (i)	9. Children:
(VI) and 1902(1) (1) (C) of the Act	a. who have attained 1 year of age but have not attained 6 years of age, with family incomes at or below 133 perce of the Federal poverty levels.
1902 (a) (10) (A) (i) (VII), 1902 (l) (1) (D) of the Act	b. born after September 30,1983, who attained 6 years of age but have not attained 19 years of age, with family incomes at or below 100% of the Federal poverty levels. Children born after
	July 1, 1979 (specifiy earlier date) who have attained 6 years of a but have not attained 19 years of age, with family incomes at or below 100 percent of the Federal poverty levels.
	Income levels for these groups are specified in Supplement 1 ATTACHMENT 2.6-A.
TN No. MS-98-10 Supersedes Approx TN No. MS-92-13	val Date: Effective Date:
	ATTACHMENT 'A'

Groups Covered

Citation(s)

	program;
	 d. have family income at or below: 200 percent of the Federal poverty level for the size family involved, as revised annually in the Federal Register; or A percentage of the Federal poverty level, which is in excess of the "Medicaid applicable income
TN No. <u>MS-98-10</u> Supersedes	level" (as defined in section 2110 (b) (4) of the Act) but by no more than 50 percentage points. : Effective Date:

Citation(s)	Groups Covered	
	age or b	children described above who are under 19 (18, 19) with family income at elow 133 percent of the Federal erty level.
	desc	following reasonable classifications of childrent eribed above who are under age (18, 19) with family income at or below the tent of the Federal poverty level specified for the sification
-	REA PER TO I	D NARRATIVE DESCRIPTION(S) OF THE SONABLECLASSIFICATION(S) AND THE CENT OF THE FEDERAL POVERTY LEVEL USED ESTABLISH ELIGIBILITY FOR EACH SSIFICATION.)
1902(e) (12) of the Act	been determine ofr changes in cir	r age (not to exceed age 19) who had need eligible is deemed to be eligible for a total months (not to exceed 12 months) regardless or cumstances other than attainment of the ge stated above.
TN No. MS-98-10 Supersedes	Approval Date:	
	Approval Date:	
Supersedes	Approval Date:	Effective Date:
Supersedes	Approval Date:	Effective Date:
Supersedes	Approval Date:	Effective Date:

)	State: IOWA		
Citation	Condition or Requirement	_	
	Supplement 2 to ATTACHMENT 2.6 - A specifies the resource levels for mandatory and optional categorically need poverty level $_{\pm}$ related groups, and for medically needy groups.		
	<u>Supplement 7 to ATTACHMENT 2.6 - A</u> specifies the income le for categorically needy aged, blind and disabled persons who are covered under requirements more restrictive than SSI.	vels	
	Supplement 4 to ATTACHMENT 2.6 • A specifies the methods f determining income eligibility used by States that have more restrictive methods than SSI, permitted under section 1902(f) of the Act.		
	Supplement 5 to ATTACHMENT 2.6 - A specifies the methods for determining resource eligibility used by States that have more restrictive methods than SSI , permitted under section 1902(f) of the Act.		
	<u>Supplen</u> it 8a to ATTACHMENT 2.6 - A specifies the methods for determining income eligibility used by States that are more liberal than the methods of the cash assistance programs, permitted under 1902 (r) (2) of the Act.		
	Supplement 8b to ATTACHMENT 2.6-A specifies the methods determining resource eligibility used by States that are more liber than the methods of the cash assistance programs, permitted unde section 1902(r) (2) of the Act.	al	
TN No. MS-98-10 Supersedes	Approval Date: Effective Date:		
TN No. <u>MA-91-47</u>	ATTACHMENT	'C'	
		Medical beautiful and the second of the seco	

ELIGIBILITY CONDITIONS AND REQUIREMENTS

Citation	Condition or Requirement
1902(l) (3) (E) and 1902(r) (2) of the Act	e. Poverty level pregnant women, infants, and children. For pregnant women and infants or children covered under the provisions of sections 1902(a) (10) (A) (i) (IV), (VI), and (VII) and 1902(a) (10) (A) (ii) (IX) of the Act
	(1) The following methods are used in determining countable income:
	The methods of the State's approved AFDC plan.
-	The methods of the approved title IV-E plan.
	_X The methods of the approved AFDC State plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6-A.
	The methods of the approved IV-E plan and/or any more liberal methods described in Supplement 8a to ATTACHMENT 2.6 - A.
TN No. <u>MS-98-10</u> Supersedes TN No. <u>MS-92-13</u>	Approval Date: Effective Date:
	ATTACHMENT 'D'

INCOME ELIGIBILITY LEVELS

A.	MANDATORY CATEGORICALLYNEEDY (Continued)	- 43° · · · · · · · · · · · · · · · · · · ·
	3. For children under Section 1902(a) (10) (i) (VI) of the Act (children who have age 1 but have not attained age 6), the income eligibility level is 133 percent of Federal poverty level (as revised annually in the Federal Register) for the size involved.	of the
	4. For children under Section 1902(a) (10) (i) (VII) and 1902(l)(1)(D) of the Act who were born after July 1,1979 and have attained age 6 but have not attained income eligibility level is 100 percent of the Federal poverty level (as revised at the Federal Register) for the size family involved.	age 19), the
Sup	No. MS-98-10 ersedes Approval Date: Effective Date: No. MS-92-13	<u> </u>
	ATTACHM	IENT 'E'

INCOME.	FLIGIBII	ITYLE	EVELS	(Continued)
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- B. OPTIONAL CATEGORICALLY NEEDY GROUPS WITH **INCOMES** RELATED TO FEDERAL POVERTY LEVEL
 - 2. <u>Children Between Ages 6 and 19 With Family Incomes at or Below 100% of the Federal Poverty Level</u>

Effective July 1, 1991, this group became mandatory under P.L. 101-508, Section 4601. Refer to item A.4. of this supplement for more information.

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3. Optional Targeted Low-Income Children Between Ages 6 and 19 under Section 1902(1)(1)(D) as amended by P.L. 105-32, section 473 1(b)

All children under the age of 19 years eligible under Section 1902(l)(1)(D) as amended by P.L. 105-32, section 4731(b) with family income at or below 133% of the Federal poverty level specified in <u>Supplement 1 to Attachment 2.6 page 2</u>

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ATTACHMENT 'F'

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b. Mandator Children	y Group of Children under Sect who were born after July 1,197	ion 1902(a) (10) (i) (VII) and 1902(1)(1)(D) of the Act. 79 and have attained age 6 but have not attained age 19.		
	Same as resource levels in the	e State's approved AFDC plan.		
X	Less restrictive than the AFDC levels and are as follows:			
	Family Size	Resource Level		
	1	<u>\$10,000</u>		
	<u>2</u>	<u>\$10,000</u> '		
	· <u>3</u>	<u>\$10,000</u>		
	4	<u>\$10,000</u>		
	<u>5</u>	<u>\$10,000</u>		
	<u>6</u>	<u>\$10,000</u>		
	<u>7</u>	<u>\$10,000</u>		
	8	<u>\$10,000</u>		
	<u>9</u>	<u>\$10,000</u>		
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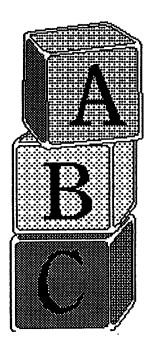
STATE **PLAN** UNDER TITLE XIX OF THE SOCIAL SECURITY ACT State: IOWA

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MORE LIBERAL METHODS OF TREATING INCOME UNDER SECTION 1902 (r) (2) OF THE ACT*

	Section 1	902(f) State	X	Non-Section 1902(f) State	
were born a creditable h poverty leve deductions,	n under Secti fter July 1,1 ealth coverage el for the fam diversions, a	on 1902 (a) (10) (i 979 and have attai ge, an additional an illy size involved s	ned age 6 but he mount equal to shall be deducte	22(1) (1) (D) of the Act (children who have not attained age 19) and who have thirty-three percent of the Federal ed from the income remaining after the ement 5a of ATTACHMENT 2.6-A are	
* More lib 1903(f).	eral methods	may not result in	exceeding gros	ss income limitations under section	
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Iowa Kids



Report of the State Children's Health Insurance Program (SCHIP) Task Force

November 1997

New Options for Providing Health Care Coverage to Uninsured Children in Families with Modest Incomes

ATTACHMENT 'I'

Executive Summary

As part of the Balanced Budget Act of 1997, Congress created the State Children's Health Insurance Program (SCHIP) by adding a new Title XXI to the federal Social Security Act. Congress also appropriated \$39.6 billion dollars over the next 10 years to fund the program.

This legislation provides states with the opportunity to create programs to provide health care coverage to targeted low-income children under the age of 19. In Iowa, the State Health Care Reform Strategy Group gave the Division of Medical. Services, within the Department of Human Services, the task of developing options as to how the SCHIP legislation could be developed. A State Interagency Work Group was convened to begin the planning process. It was determined that a task force should be appointed in order to gather input from a wide array of interested parties and to develop program options. It was further determined that the Task Force membership should include the members of the Healthy Kids Program Study Task Force that was convened in 1996, as well as legislators, and other representatives from the business, education, medical, and advocacy communities.

The Work Group determined that gathering input from Iowa citizens was critical in developing program options. Eighteen public forums were scheduled in nine communities throughout the state. The media, direct mailings, and the distribution of over 70,000 flyers statewide were used to notify tizens and interest groups of the forums. Additionally a toll-free telephone number, a fax line, and an e-mail site were established to gather input from persons who could not attend the forums.

The public forums and other methods established to garner input provided an opportunity for citizens to help shape the program options and gave the Task Force and Interagency Work Group additional information and insight **as** to how best structure a program in Iowa to provide health care coverage to **uninsured** children. Forum participants strongly supported the creation of a program to provide health care coverage to uninsured children. Participants most often cited the new welfare reform policies, the belief that an increasing number of two-parent

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families are working for wages under 200% of the federal poverty level, and a declining number of employers providing family health plans as reasons to support the creation of a **children's** health *care* coverage program. It was noted that schools and other public and private agencies should be involved in **assisting in** the creation and implementation of **this** program. It was also felt that employers and providers should play a critical role in ensuring that any new program works effectively and efficiently.

There was strong sentiment **to** make sure that the Title XXI program coordinates with the. Title XIX program. Public forum participants **also** strongly felt that **state** policy makers should learn **from** previous experiences with **Medicaid**, make necessary and important corrections, and ensure a seamless children's health **care** coverage program. There was also clear recognition of the value of Title XIX and the belief that it could provide the structure upon which **to** build a health care program for uninsured children.

Preventive services for children were identified as the key health benefit Iowans want for their children. In addition to medical benefits required under the federal legislation, mental health services, vision, dental, and prescription drugs were cited as very important services. Citizens also endorsed the concept of cost-sharing for those participating in the program. Sliding fee scales, co-payments at the provider level, or premiums and/or deductibies were noted to be important as "buy-in" by families, as well as to help in managing utilization.

The Task Force created two subgroups to address specific issues. The "Who/What" group was given the charge of developing options around the program structure, benefit design, eligibility criteria, "crowd-out," and private sector issues. The group identified and prioritized five general options for the structure of the program:

- **1.** A public/private partnership (i.e., Medicaid expansion along with a separate child health program);
 - 2. A private program only;
 - 3. A voucher system;
 - 4. A Medicaid-only expansion; and

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5. Tax treatment.

The "How" group was charged with addressing administrative issues, and marketing and outreach. Building upon the "Who/What" group's deliberation, the "How" group recommended the option to expand Medicaid to 133% of the federal poverty level in conjunction with the implementation of a separate program for children living in families with incomes between 133% and 200% of the federal poverty level. The program design should be flexible in order to accommodate future modifications.

Although the **Task** Force **was** unable **to** develop options on **all** of the issues, **as** a result of the **community** forums, citizen input, and the deliberations and recommendations of the two subgroups, the **Task** Force developed guiding principles and values on which options developed by the Interagency **Work** Group should be based. The principles and values address:

- 1. Eliminating barriers to coverage;
- 2. Access;
- 3. Outreach and education (for Title XIX and Title XXI);
- 4. Benefits
- 5. Participation in the program; and
- 6. Cost sharing.

The Task Force made the following recommendation and strongly endorses it **as a** program option:

Expand Medicaid to 133% of the federal poverty level for all children under the age of 19 and create a separate private health care coverage program for children up to the age of 19 who Live in families with income up to 200% of the federal poverty level as allowed by the federal legislation.

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State Children's Health Insurance Program (Title XIX)

Process to Develop Program Options

Iowa's efforts to develop a children's health **care** coverage program as **a** result of recent federal legislation under Title XXI focused on **crating** an effective and efficient program **that** covers **as** many uninsured Iowa children **as** possible. The process to develop program options included an Interagency Work Group, the State Children's Health **Insurance** Program Task Force, and most **inportant**, the citizens **of** Iowa. This process was conducted during September, October, and November **1997** and focused statewide attention on the issue and gathered valuable input for consideration in developing program options.

The Interagency Work Group was responsible for setting the process in motion, for receiving the public comments and results of the Task Force deliberations, and ...for developing recommendations to be forwarded to the Governor for consideration. State agencies represented on the Interagency Work Group included the Insurance Division, Department of Human Services, Department of Public Health, Department of Personnel, Department of Management, Department of Elder Affairs, Department of Education, Workforce Development, and the Office of the Governor. This work group met weekly to guide and monitor the process and to review information as it was developed.

The State Children's Health **Insurance** Program Task Force was formed to help guide the process and to provide information to the Interagency Work Group. The Task Force membership included members of the Healthy **Kids** Program Study Task Force that studied the issue of children's health care coverage in the Fall of 1996, members of the Interagency Work Group, legislators, and representatives from the business, education, medical and advocacy communities. The 33-member Task Force met **twice** and was represented at each of the **18** public forums.

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The most intensive part of the option development process was the information gathering from citizens and stakeholders throughout the state. A variety of methods and means were used to ensure a number of opportunities for Iowans to participate **in this** process. The outreach component included the following activities:

- Direct mail effort—A direct mailing was targeted to the members of 42 organizations. In all, more than **18,000** pieces of mail were sent, each including a letter explaining the children's health care coverage effort in Iowa, a flyer inviting them to attend one of **18** forums throughout the state, and a fax-back form to elicit responses from those persons unable to attend a forum.
- Organizations effort—Special letters were sent to 28 organizations and associations with
 interest in these issues. The organizations were provided information about the children's
 health care coverage program development process and invitations to participate in the
 community forums. These groups were also asked to support the effort by disseminating
 information and helping publicize the outreach effort.
- School systems—Each K 12 school superintendent was contacted by fax with information about the outreach effort and an offer to provide take-home information to students and posters to be placed in the schools. Requests for brochures and posters were received from 124 school districts, resulting in distribution of 72,000 brochures to inform parents of the outreach forums.
- a Public access points—Letters explaining the effort were sent with posters announcing the community forums to all Iowa public libraries and local Department of Human Services offices.

Community forums—Bighteen community forums were held in nine Iowa communities between September 25 and October 15 – Waterloo, Ottumwa, Clinton, Red *Oak*, Creston, Storm Lake, **Des** Moines, Washington, and Cedar Rapids. A late afternoon session and an early evening session were held in each community to accommodate varied schedules and needs of potential participants. Each person attending a forum received a booklet explaining the children's health care coverage development effort in Iowa.

Each forum was conducted by **an** experienced facilitator using a discussion script which provided an introduction and overview of the Title XXI legislation and Iowa's efforts to develop a children's health care coverage program. The forums concentrated on gathering input from participants in response **to** a set of questions that were developed to stimulate discussion of key concerns. More **than 500** people 'attended the **18** meetings. Comments from each meeting were captured and provided to the Task **Force** and Interagency Work Group in the form of individual forum reports **and an overall summary** of the forums.

- Response gathering—Each person receiving a letter, flyer, or brochure about the initiative was given an opportunity to provide input in alternative ways if they were not able to attend one of the public forums. Responses to specific questions were solicited through a fax-back form. Individuals were also provided with a toll free number and e-mail address to use to offer suggestions. The information received through these methods was assessed and grouped according to response. These responses were then charted to create another form of public input for consideration by the Interagency Work Group in developing program options.
- Media and publicity—State agency and Task Force members conducted a number of interviews with newspaper and radio throughout the state. Several of the community.
 forums received coverage by local media as well.

All input collected from the outreach effort was forwarded to the Interagency Work Group and the State Children's **Health Insurance** Program **Task** Force for their consideration.

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Public Forums

Summary of public discussion:

Public discussion at the **18** public forums was guided by a "script." The script, which provided background information regarding the, new federal legislation, helped focus on specific questions and issues that were important to the Interagency Work Group and the **Task** Force. Written comments were also received **fiom** individuals and **interest** groups **as** a part of the forums.

The following is a *summary* reflecting the general comments in response to each question in the **forum** script.

<u>Section I</u>: This section focused on the potential number of Iowa children who do not have health care coverage. Based on that information, the following questions were asked:

Q: In your opinion, what are the major barriers that currently exist preventing families from having health care coverage for their children?

In **lowa**, there is a growing number of "working poor" who hold minimum wage jobs. Also, with welfare reform, more single mothers are working toward becoming self-sufficient. Because these jobs are entry level pay, there is a bowing number of Iowans who lack the necessary income to pay for health **insurance** for their children.

National research indicates that the number of employers providing health *care* coverage for employees' dependents is decreasing. In the event dependent coverage is offered, deductibles are frequently **high.** For those who are not covered by an employer plan, premiums are often too expensive, deductibles are too **high,** or there may be preexisting conditions that **limit** the ability to be covered at all. Many of the **uninsured** are self-employed, are dependent on seasonal work

as the mainstay of their income, change jobs frequently, are farmers, or are small business owners.

There is also the notion that, for many families, health insurance is not a priority. It is difficult for many to connect the consequences of illness or **injury** with **costs** to the family, and health insurance is not thought about **as** being important, or it **seems "unattainable."**

Q: If you could decide, what would be the ideal place/way to receive coverage for children? (By place/way, meaning where.....through schools, employers, local or state government offices, or other.) And why?

Many felt that schools should be the first point of contact and the best place for families to access information about **the** program or to enroll in a children's health care coverage initiative. Recognizing that those families with children **0-5 years** old would also **need** access to coverage, the schools serve **as** the logical location in neighborhoods and communities. It was noted that using the schools did not necessarily **mean** that school officials and teachers should be responsible for this new activity. In addition, there should be an effort to develop broad integrated opportunities for families to easily access coverage throughout the community. Many current programs should be used in developing information and access to a children's **health** care coverage program for example: Title V, Maternal Child Health Program, public health, visiting nurses, Head **Sact.**, registered day care centers.

There was also support for encouraging health care providers to participate in providing information or even be a place for families to access the program. Hospitals and physicians were suggested as a logical point for information or enrollment. State government offices were not frequently cited. It was also noted that access'should be where people go. Examples often cited were grocery stores, drug stores, and other public places where people conduct daily living activities. The idea of "non-traditional" locations was cited often.

<u>Section II</u>: This section focused on the potential structure that may be developed to provide health care coverage to those children who currently are not covered. The federal legislation allows the following methods to be used in the development of the new initiative.

- -Expand the current Medicaidprogram
- -Create a separate child health insurance program
- -Directly purchase private insurance coverage/subsidizing an employer plan
- -Directly purchase services for children

Based on that information, the following questions were asked:

Q: If you were responsible for designing the Iowa program, which method(s) would you use and why? (What do you believe may be other methods?)

Generally, with the exception of the expansion of Medicaid, there was not a clear understanding as to the specifics of the proposed methods. There was some sentiment for the expansion of Medicaid, primarily because it would alleviate additional administrative costs, and because it could provide comprehensive coverage. At the same time, there was a concern about some of the problems Medicaid expansion might bring if there are not some revisions to the current Title XIX delivery methods.

There was some sentiment for directly which will be less bureaucratic and easier for families. It was thought that direct purchase might be less bureaucratic and easier for families.

Some thought that creating a separate child health care coverage program would be most appropriate. It would eliminate the Stigma that many feel is associated with receiving Medicaid. Some felt that families enrolled in the Medicaid program were "stereotyped," and Medicaid expansion may add to that problem. Creating a separate child health care coverage program would take the responsibility out of government's hands and reduce stereotyping of participants'

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families. Others argued that they were concerned that the program could take on a "managed care" model if it was placed outside of government control. To some, private contracting or allowing the children's health care coverage program to be managed by a private insurance company was a concern.

Some participants were proponents of directly purchasing private insurance coverage or subsidizing an employer's program. It was noted that placing such a program in the private sector may be helpful in reducing stereotyping, and might serve as a means to encourage businesses and the private sector to provide needed benefits to employees.

There was strong support for combining the expansion of Medicaid with the creation of a state children's health care coverage program. A first step would be to expand Medicaid to a higher percentage of the federal poverty level. In the second step, Medicaid expansion would be coupled with a separate private or publicly administered children's health care coverage program. Participants pointed out that this structure would provide expanded Medicaid coverage, allow the two programs (Titles XIX and XXI) to be linked and become more seamless, minimize the stigma to families, and blend the best of both programs.

Q: Which program methods would not be effective in reaching uninsured children and should be avoided in designing the program?

Most participants readily admitted that developing this program was very complicated and they did not understand or envision the details of any of these methods.

There was broad opposition to merely expanding the current Medicaid program. Individuals were concerned that this would simply expand the stigma of Medicaid. Another concern was that there are a number of administrative problems with the current Medicaid program including the complicated enrollment process, complex eligibility criteria, and high staff turnover. Additionally, some providers are not taking Medicaid patients, and provider reimbursement rates are too low.

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It was noted by some at each forum that simply creating a separate child health care coverage program could create a major bureaucracy. There were fears that if the state subcontracted the program to a private vendor, there might not be equal access to providers throughout the state. There was **also** a fear that a separate child health *care* coverage program would be structured **as** a managed care program and some parents, especially those with **special** needs children, would not get to select or continue with their current providers.

There was **also** a concern that in purchasii private insurance through the employer, employers might take advantage of the new children's health care coverage and move people **off** an employer-sponsored program on to Title XXI and have their employees covered by the state program. It was difficult for participants to determine how **best** to make **this** method fair to employers and fair to employees and families. There was little opposition for the proposed program to directly purchase services for children fiom qualified providers.

<u>Section 111</u>: This section focused on the Medicaid (Title XIX) program, because it is important to link it to the state children's health care coverage program. It is estimated that a large number of children in Iowa are eligible for, but not participating in Medicaid. These same children are not eligible for Title XXI. Based on that information, the following questions were asked:

Q. Why do you think eligible families do not participate in the Medicaid program?

It was noted that there is a concern about the stigma of receiving Medicaid. Many noted that the process is extremely bureaucratic and the forms that **need** to be completed are complicated and intimidating. Sometimes transportation is a problem, given the requirements to come to the office to enroll.

It was also pointed out that many people know Medicaid is available and know how the system works, but will not sign up for Medicaid until they need to use it. Some families have an anxiety

about being involved in any government program or even an insurance program. And to some, health care or the ability to cover health problems is not an issue or priority.

Q: What do you believe is the most effective way to educate (inform or make aware) families to the fact that their children are currently eligible for Medicaid coverage?

The majority suggested that information be provided in a different format. Traditional methods such **as** letters, posters, and other printed material should be expanded to audio and visual methods. There were **also** suggestions to expand access to the information to outside of traditional government offices and into logical places in the communities. It **was** also suggested to limit the use of government "jargon" and make the information easier to understand.

<u>Section IV</u>: This section focused on the benefits that the federal legislation required, as well as those benefits that Iowans believe should be included. Standard benefits required include well-child exams, physician visits, lab tests, x-rays, and immunizations. Based on that information, the following questions were asked:

Q: Considering the standard benefits, what other benefits do you believe should be included in the Iowa children's health care coverage program?

Coverage of vision screening, dental care, prescription drugs, and mental health services were strongly supported in each of the forums. Participants described the growing concerns and great lack of mental health services to children. It was often noted that dental services have not been viewed by the public as a vital health care concern. Other services frequently mentioned as important include services for special needs children, audio services, case management, health education, and health promotion services.

Q: Should benefits include mental health, dental, vision? What should be the minimum standards of care?

These benefits were included in discussions at all forums. There was also discussion about minimum standards of care. Many providers felt that *standards* established by their respective

professions should be the minimum standards of care u s by the program. Forum participants felt that a minimum standard of care was critical to ensure quality treatment to the children of **Iowa**. There was a feeling that there should be standards and accountability for all providers in the program.

Another issue that often became a part of the discussion related to the importance of measuring the benefits of a children's health care coverage program. Although measuring outcomes would be very difficult in a short period of time, it was the general feeling that the state **must** develop methods to **measure** health outcomes and identify **cost** benefits that may result from a children's health **care** coverage program. It was felt that this kind of effort will help determine if additional funds should be appropriated to expand or continue the program.

Q: How should the benefits provided be prioritized?

Generally, forum participants understood that only so much money is available and that it may be necessary to determine priorities. Many participants expressed the hope that the program could be structured to give each child or family the services they most need. Others suggested that the program may limit certain services where they are most appropriate for screening and other prevention efforts. (For example - screening for vision is most appropriate up to a certain age.) It was the general feeling that we should use the funding to provide the most/best services to the largest number of uninsured children, with the recognition that the services should be similar (as much as possible) to those of the Medic id program.

<u>Section V</u>: This section focused on appropriate ways for families to participate in this initiative. The legislation allows a sliding fee scale, based on income and the size of the family. Families can also participate with cost sharing through coinsurance, paying parts of premiums, or deductibles. Based on that information, the following questions were asked:

Q. What would be the most appropriate ways for families to financially participate in the program? (Premiums, co-payments, deductibles)

Overwhelmingly the participants thought that there should be financial participation at some level by families in this program. Certainly, a sliding fee scale, based on income and family size, was acceptable. There was some sentiment for cost-sharing in the form of premiums, as this would allow families to budget for those costs and not penalize families with sick children who access care frequently. In addition, many thought that participants should have some level of copay, as long as it was not a deterrent to seeing a provider. For the most part, although co-pays are sometimes hard to collect, providers (and others) felt they were important to engage families in the investment in the health care of their children, involve them in the program, and also to provide a way to manage utilization of services.

There was not as much agreement on asking for cost-sharing on premiums with employers. There was a concern about the difficulty in managing the employer's participation and continued involvement. If there could be a way to involve employers fairly, many thought that it is important to work with small businesses and help them offer this benefit to employee families. There was also some sentiment for helping families buy down deductibles through employers, if possible.

It was noted that this income bracket would most likely be very supportive of financially participating in their own children's health care coverage program. Many in this income bracket are working, want to improve their lives and the lives of their families, and don't expect to receive **free** coverage.

Q: How much could a family afford to pay to participate in an insurance program? (% of total income)

Most people could not answer this question. A common theme was that because the family income is low for those who are eligible, the percentage of that income to participate in fees or co-pays would have to remain very low, given the other basic needs of the family.

Principles and Values to Guide Decision Making

The Task Force reviewed the key issues important in shaping a children's health care coverage initiative for Iowa and developed the following "principles and values" to guide the Interagency Work Group and policy makers.

Principles and Values to Address Barriers to Families Getting Coverage for Children

- Employers should offer health *care* coverage for children
- Employees should access health care coverage for their children
- Coverage should be affordable
- The program should be *easy* to understand
- The program and health care should be accessible
- There should be no stigma associated with getting health care coverage for children

Principles and Values to Address the Ideal Place to Access Coverage

- A multi-access approach should be established
- Access should be friendly to families
- People should be able to enroll in or **near** home
- There should be no stigma associated with enrolling or receiving **services**
- It should be as easy and fair as possible to enroll; use attestation, not proof

Principles and Values to Address Methods of Receiving Health Care Coverage

- The system should be as seamless as possible to the individual, provider, and in administration
- Benefits should be as comparable as possible to Title XIX benefits
- Provide coverage to the most children possible
- Minimize disincentives to keeping employer-offered coverage
- Promote self-sufficiency
- Subsidy would diminish as 200% of the federal poverty level is approached
- **Ensure** flexibility in the program to allow parents with income above 200% of the federal poverty level to buy into the program

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Principles and Values to Address Outreach and Education

- Base outreach on established principles of marketing
- Use an integrated marketing approach
- Targeted marketing with different messages for different audiences
- Emphasize enrolling children **0 5**
- Establish accessible counseling on eligibility
- Provide benefits to the **most** children possible
- Use schools and other appropriate institutions for outreach and education
- Use printed materials that are reader-friendly
- Conduct public education -- audience beyond potential users

Principles and Values to Address Benefits

- Improve health status
- Prevent disabilities
- Focus on outcomes
- Ensure services with developmental and educational value
- Offer broadest array of benefits, recognizing utilization needs to be managed
- Ensure the greatest good for the greatest number of children
- Ensure use of state and federal dollars in ways that give the most long term benefit to children and society
- The program will evolve **based on** evaluation
- Any plan developed that meets the goals of affordability and "wantability" to consumers (they will buy it) and whose benefits are outcome based (glasses to see the chalkboard, hearing aids to hear teacher, etc.) and that follows the principles of providing the greatest good to the greatest number of people with the funds available should meet the criteria and the basic values of this group.

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Principles and Values to Address Participation in the Program

- Reimbursement rates must be adequate to support providers
- Cost-sharing (for premium only) should be linked to family income
- The program should look like insurance, not "welfare"

Thank You

The Task Force members would like to thank all who attended the forum and otherwise provided input. Also thanks to State Public Policy Groupforfacilitating the Task Force meetings and public forums.

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